PATIENT FINANCIAL RESPONSIBILITY
ASSIGNMENT OF BENEFITS

Providing information about your insurance coverage is important. Comprehensive Blood & Cancer Center will make every effort to obtain authorization for the requested services from your Medicare and/or your private insurance company. We will also bill Medicare and/or your insurer for the services that we provide. By signing the Form you authorize the payment of insurance benefits to CBCC for the services provided to you.

By signing the form you also authorize the release of medical information to your insurance company and to any other physicians participating in your medical care.

Medicare and private insurance companies may not cover the services requested by your physician or they may only pay a portion of the amount that Comprehensive Blood & Cancer Center bills to them. For example, patients are typically responsible for paying deductibles, co-insurance, and co-payments. By signing the Form you acknowledge that you are responsible for the amounts not paid by Medicare and/or your insurance company. By signing you also agree to meet with the Comprehensive Blood & Cancer Center's Financial Counselor to arrange a payment plan for any outstanding balances. The counselor will work with you to make these payments as easy as possible on you and your family.

PET Scans: For patients receiving PET scans there is an additional obligation. Since the materials used in the PET scan must be specifically ordered for each patient, PET scans may only be cancelled up to 24 hours before the exam is scheduled. After this time period, patients canceling a PET scan will be charged the cost of the unused dose.

Patient Signature _____ Date Signed _____

Print Patient Name _____

INSURANCE ELIGIBILITY CERTIFICATION

I understand that it is my responsibility to provide the Comprehensive Blood & Cancer Center with accurate information regarding my Medical Insurance Coverage. Should there be any change in my coverage I agree that I am responsible to notify CBCC of the changes and understand that should I fail to do so, I will be financially responsible for any resulting unpaid claims.

Patient Name _____

Patient Signature _____ Date _____

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